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2 October 2010

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- Dermatologically tested
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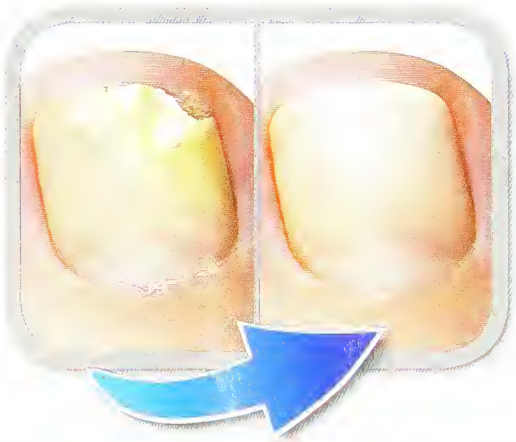

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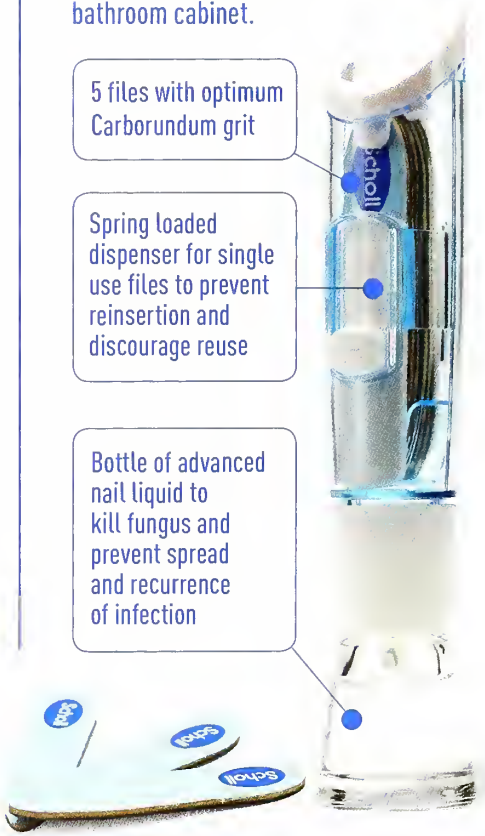

For more information on Scholl Fungal Nail Treatment visit www.scholl.co.uk or call the Scholl team on 0800 074 2040.

1 Data on file.

Sch87 01

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2 October 2010

Disciplinary shambles

New regulator inherits £6m case backlog from RPSGB

Four year wait for hearings 'horrendous', say legal experts

EXCLUSIVE – GPhC 'will leave no stone unturned' to improve efficiency

Full story on page 6

Insightful
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Pfizer *Listening to pharmacy*

a healthy partnership™

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PPA ABC

> NOBODY DESERVES TO HAVE THEIR LIFE PUT ON HOLD FOR THE BEST PART OF FOUR YEARS WAITING FOR A VERDICT

Making a mistake is bad enough, but when the error could be a matter of life or death it is a traumatic experience for both patient and pharmacist.

Whether the error is a genuine accident or down to poor working practices makes no difference: pharmacists don't willingly choose to make errors and certainly don't choose to go through the gut-wrenching worry that follows. We've all been there and it is one of the worst feelings in the world. And then, should you be unlucky enough to be the subject of a complaint to the Royal Pharmaceutical Society, the level of anxiety just increases.

A report instigated by the incoming regulator, the General Pharmaceutical Council (GPhC), into the RPSGB's fitness to practise (FtP) procedures (p6) has revealed that pharmacists are waiting around 15 months for their cases to pass through the initial investigations and preparation stages prior to being heard by the investigation committee.

And when you factor in the time taken (not to mention the cost) for a case to be dealt with in the pre-disciplinary committee stages, some pharmacists remain in the disciplinary system for a staggering 46 months.

This is simply unacceptable. Nobody deserves to have their life put on hold for the best part of four years waiting for a verdict to be handed down.

And fortunately, the GPhC agrees. Chief executive Duncan Rudkin's candid interview with C+D is a revealing insight into how the new organisation will overhaul the regulatory process. Whether it's the additional staff training, the use of procurement experts to drive down legal costs or the desire that everyone in the process – including the accused – should be treated with respect, you get the sense regulation will be an altogether different experience on Mr Rudkin's watch.

Being the subject of an investigation is never going to be pleasant, but if the GPhC delivers on its promise to make the process cheaper and quicker, and to treat those caught in the FtP machinery with courtesy and consideration, it has to be better than the scenario outlined in its report.

We should never forget that not every pharmacist who is investigated is guilty, and often those who are at fault simply require guidance and support to improve. An FtP process that encompasses these ideals must surely be better for both pharmacists and patients.

Gary Paragpuri, Editor

'Appalling' RPSGB record revealed

Cost to GPhC of clearing disciplinary case backlog could reach £6.6m, report finds

Zoe Smeaton
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It would cost the General Pharmaceutical Council (GPhC) between £3.2 million and £6.6m to clear the disciplinary cases it has this week inherited from the RPSGB, if the new regulator continued on the same cost basis as the Society.

A due diligence report into the RPSGB caseload found the Society used to spend on average £11,581 per Disciplinary Committee hearing day – including £1,927 on room hire, hospitality and shorthand – or £24,132 if external legal experts were used.

The RPS said the report had been noted by Council at its last meeting and added it had "no further comment on this matter at the current time" (see response below).

Concerns were also raised over the time taken by the Society to deal with fitness to practise cases. The report found it took about 15 months for serious complaints to pass through the investigations and preparation stages before being heard by the Investigating Committee. And for serious complaints to pass all the way to the Disciplinary Committee took almost four years in most cases.

Experts called this "pretty horrendous" and one C+D reader posting online said: "Four years to get to [the] Disciplinary Committee is obscene."

The GPhC said it was already looking to make improvements. Chief executive Duncan Rudkin told C+D he didn't think the profession or the public would find the time being taken to deal with cases acceptable. "There's a huge amount we need to do to make the existing machinery work more efficiently," he said.

Mr Rudkin said the senior management team had been leading a cultural shift in regulation. Measures would include improving both the non-referral criteria and the investigating process. The Council has also developed case management directions to drive the process of getting cases to hearings.

Mr Rudkin promised the GPhC would be rigorous in challenging itself on costs using external procurement experts to help. He hoped the Society's legal advisers would be feeling "slightly nervous".

Mr Rudkin said he could not give estimates of how much more efficient the GPhC would be nor future fee levels. "I'm not going to pluck a figure out the air. At any given point we will always want it to be better, and quicker and more efficient and cost-effective," he said.

Read Duncan Rudkin's interview in full online
www.chemistanddruggist.co.uk

David Reissner comments

I probably could have guessed a lot of the findings in this report, but there are still some real nuggets in there. I was surprised, for example, to see the costs to the Society of external lawyers – £11,400 is an awful lot for a day as routine. I'd be interested to know whether the legal services were put out to tender at any time.

For the GPhC I think the biggest improvement that needs to be seen is the speeding up of the investigating process. We know it takes an awful long time for cases to go from start to finish, but there has been a lot of focus on the time taken in the hearing stages and less on the time taken to move from a case being investigated to the Investigating Committee. These could be cases where the pharmacist hasn't done anything that merits pursuing, yet the report shows they still have the case hanging over them for 15 months on average. Fifteen months just to get to that interim committee stage in a case is appalling.

We could also see the committees sitting for longer – some GMC committees are in almost constant session – and improvements in the process. At the moment committees can have several deliberations on one case and they're taking longer than they should, which costs more money for everyone, especially the members. The RPSGB also said it would be pumping money into the system to enable the disciplinary committee to sit more often, but I haven't sensed any speeding up.

David Reissner is a specialist in pharmacy law and head of healthcare at Charles Russell LLP

Society was 'over zealous'

PDA chair John Murphy said it was nice to see the report recognising that the number of complaints per registrant which the RPSGB receives is high relative to other regulators.

He told C+D: "I'm not sure I completely agree with the reasoning that that's because we're patient facing. I think it's more a symptom of the Society wanting to be the most diligent regulator."

He said the GPhC now had to work with the legacy of an "over zealous regulator" but that he had "quite a lot of confidence that they are going to try to put things right".

RPS has confidence in new regulator's commitment

In response to the due diligence report the Royal Pharmaceutical Society (RPS) issued a statement saying regulation had transferred from the Society to the GPhC.

"GPhC has now assumed responsibility for the current fitness to practise caseload of the RPSGB," it said. The RPS added: "In advance of transfer a due diligence report was commissioned by the GPhC executive; this report was seen and noted by the RPSGB Council at its last meeting."

The RPS said it was reassured the GPhC, as a new organisation, was committed to ensuring fitness to practise investigations were undertaken in a proportionate and timely manner, while remaining committed to fairness and thoroughness.

In response to further questioning on the due diligence report and specifically the time taken to deal with cases and the costs associated with hearing days, Neal Patel, head of corporate communications at the RPS, told C+D the statement "says all the RPS, the new professional body, has to say on this matter at the current time". **ZS**

RPS chief promises 'very different' leadership body

Championing the role of pharmacy in healthcare is key priority

Jennifer Richardson
jennifer.richardson@ubm.com

The Royal Pharmaceutical Society (RPS) will be "very different" to the RPSGB, the chief executive of the new professional leadership body has pledged.

As the RPSGB officially split at the beginning of this week, shedding its regulatory function to become the RPS, Helen Gordon told C+D it would "champion the role of pharmacy in healthcare, and also at a local level, in a way that hasn't been done before and certainly can be done in an enhanced way".

C+D took readers' questions to Ms Gordon who said she was "very well aware that there's still more to be done to ensure that the public [and] also a whole range of healthcare professionals understand pharmacy's role".

The RPS would be working with "frontline" pharmacists to provide evidence of the impact of the profession to other healthcare organisations, she said.

Ms Gordon also pledged to develop the RPS's guidance, advice and signposting services "into something that will feel quite different to pharmacists", and promised more "personalised" support.

Feedback from users of these support services was already indicating progress, she said. But Ms Gordon acknowledged there was further "room for improvement" and said the RPS would "constantly be listening to members" to achieve this.

Chief executive Helen Gordon: the RPS will "completely focus" on support

Asked by C+D reader Bob Gartside if the RPS would become "leaner and meaner", Ms Gordon responded: "We think we have got the right people for the job in hand, but it won't stop there; we'll be constantly evolving... so we can make sure that every pound of members' money is spent in the best way possible."

The separation of the RPSGB into the RPS and new regulator the General Pharmaceutical Council (GPhC) would allow the former to "completely focus on the support of pharmacists and pharmacy", Ms Gordon said, and meant the profession would "get more out of the national bodies".

For the full readers' Q&A with Helen Gordon, don't miss next week's issue of C+D, and watch the videos at
www.chemistanddruggist.co.uk/video

'Shocking' service spend variations

C+D's PCT Investigation has revealed shocking geographical variations in pharmacy service funding levels, experts have said.

The investigation shows spending on advanced services varies between trusts by as much as 300 per cent, with reported enhanced service spends being as little as £150 per pharmacy per year.

Mimi Lau, Numark's director of professional services, said: "We hear anecdotal evidence all the time, but seeing these figures in black and white really shocked me." Ms Lau said she would be very interested to know the correlation between spending and areas of apparent wealth or deprivation.

PCT INVESTIGATION

"What we signed up to in the contract was that a category M mechanism would put money back into services, but looking at these figures some contractors are benefiting from this and some aren't," Ms Lau continued.

"This is unfair for contractors, and PSNC and the Department of Health must make it a priority to address," she added.

For the full results and analysis of C+D's PCT Investigation 2010 see next week's C+D and go to www.chemistanddruggist.co.uk after October 9. **ZS**

In brief

Lundbeck supply deal

Global pharmaceutical company Lundbeck has appointed Alliance Healthcare as the sole distributor of its products in the UK, in a move designed to improve supply chain efficiency, Lundbeck said.

NHS reforms challenged

Healthcare workers' union Unison has been granted a legal hearing to be heard on October 13-14 into the merits of a judicial review against the secretary of state for health over the lack of public consultation on the white paper.

Public health roundtable

The NPA was hosting a roundtable to advise Department of Health officials on community pharmacy's role in public health as C+D went to press. The discussion was set to include presentations from chief pharmaceutical officer Keith Ridge and grassroots pharmacists.

Welsh EPS applauded

Pharmacy support group Numark's IT steering group has recommended the Department of Health look to the Welsh 2D electronic prescriptions model to help avoid pharmacists having to cope with download times. Andy Charlesworth, Numark's IT services manager, said: "The message to Connecting for Health from the committee is clear: adopt this model; it works."

PSNC defends MURs

MURs play "a crucial role" in boosting medicines adherence, PSNC has said, hitting back at claims the service was "bordering on fraud". PSNC issued the defence in response to headlines in GP magazine Pulse last week, based on a study that raised concerns about MUR quality (C+D, September 25, page 10).

Call for cat M overhaul

AAH managing director Mark James has called on the Department of Health to address "the crippling uncertainty around Cat M clawbacks" and replace the system with a more predictable mechanism to enable businesses to manage cash flow.

Dispensary talk

Are pharmacists the best people to talk to men about Viagra?

"Of course we are. We can offer a discreet, convenient service and that's what patients are looking for." **James Wood, Wicker Pharmacy, Sheffield**

"Men probably won't ask us unless they already have a good relationship with us. Unfortunately a lot of men aren't good at asking healthcare professionals for advice." **Linda Bracewell, Baxenden Pharmacy, Lancashire**

Web verdict

Yes, pharmacists are accessible 49%

No, I wouldn't feel comfortable 46%

Unsure 5%

Armchair view: It's a pretty even split for Viagra, with around half of pharmacists playing the convenience card but others unsure about taking on the responsibility.

Next week's question:
Do you think the GPhC will do a good job clearing the RPSGB's outstanding cases? Vote at **www.chemistanddruggist.co.uk**

Crucial role for sector as Avandia is withdrawn

Discuss issue with patients and refer to GPs, advises RPS

Gavin Atkin

Community pharmacists are being asked to send patients to see prescribers after drug regulators withdrew popular rosiglitazone-based type 2 diabetes treatments, used by 100,000 patients in the UK.

Experts warned patients were likely to be concerned about the change and might not understand the full details until they visited their pharmacies.

In line with Nice guidelines, many patients will be switched either to pioglitazone (Actos), another glitazone class treatment, or to injectable treatments such as the DPP4 inhibitors or even insulin.

The European Medicines Agency (EMA) recommended suspension of the licence for Avandia and Avandamet, rosiglitazone-containing treatments, following a review that found the benefits no longer outweighed the cardiovascular risks.

Supplies of Avandia and Avandamet will cease to be available in Europe within the next few months. Manufacturer GSK is recommending prescribers should not issue new or repeat prescriptions of rosiglitazone-containing medicines, and should switch patients to suitable alternatives.

Simon O'Neill: patients will want to know why they can't have their treatment from pharmacies

Patients were advised to discuss treatment with their prescribers but should continue taking the treatment for the time being in order to maintain blood sugar control.

The Royal Pharmaceutical Society advised pharmacists receiving prescriptions for Avandia or Avandamet to discuss the issue with the patient and recommend they see their doctor. If appropriate, pharmacists should contact the prescriber directly.

Diabetes UK care director Simon O'Neill said many patients had been taking the treatment quite happily and some would want to know why they couldn't have their medicine.

"Some will only find out the drug has been withdrawn when they go for their repeat prescriptions," he added. "They may only find out their treatment is no longer available when they are in the pharmacy."

Mr O'Neill suggested pharmacists could contact doctors to ask how they planned to manage the drug's withdrawal, and to pass this information to patients.

The story behind the withdrawal of rosiglitazone

Full analysis page 14

PSNC and DH working on specials price tariff

PSNC and the Department of Health are hoping to make progress on a tariff for the most commonly prescribed specials medicines within months, PSNC chief executive Sue Sharpe has confirmed.

Mrs Sharpe spoke on BBC Radio 5 Live last week, responding to an investigation highlighting the high prices sometimes paid for specials.

Until such a tariff is developed, pharmacists were advised by the Royal Pharmaceutical Society (RPS) that they should procure specials in a "professional manner" and try to ensure value for the NHS.

The BBC investigation estimated over £70 million per year could be saved if an upper limit was placed on specials prices. And Mrs Sharpe agreed too much was being spent on the medicines.

"We know we've got a problem here. We've got some high prices being charged for specials, and there's work that needs to be done to make sure that the NHS is getting good value," she said.

Mrs Sharpe added that she was hoping for progress on the tariff "within the next few months".

The RPS said pharmacists should have an SOP in place for obtaining specials, but should bear in mind that price was just one factor in assessing cost effectiveness. **ZS**

Rogue online pharmacies pursued by Google

Google has filed a federal court lawsuit against online rogue pharmacies that it believes have broken its advertising rules.

The move was welcomed by Neal Patel, the Royal Pharmaceutical Society's head of corporate communications, who told C+D: "Unscrupulous people providing prescription-only medicine without a prescription should be brought to book and we applaud Google's stand on this issue."

Google said it had noticed a marked increase in the number of rogue pharmacies and sophistication of their methods in recent years. This had come despite the company changing its advertising policies and using automated keyword blocking and verification procedures.

Michael Zwibelman, a spokesperson for Google's litigation counsel, said: "Rogue pharmacies are bad for our users, for legitimate online pharmacies and for the entire e-commerce industry, so we are going to keep investing time and money to stop these kinds of harmful practices."

Google said it would continue to add additional rogue pharmacies to the lawsuit as it identified them. **SP**

"The little difference that makes a big difference."

Product Information Panadol Advance 500mg Tablets. **Presentation** Paracetamol 500 mg. Contains disintegrant system to accelerate dissolution. **Uses:** Mild analgesic and antipyretic. Headache, migraine, tension headache, toothache, backache, rheumatic and muscle pain, dysmenorrhoea, sore throat, feverishness, aches and pains of cold and flu, pain due to non-serious arthritis. **Dosage and administration.** *Adults and children, 12 years and over* Two tablets up to four times daily as required. Max. 8 tablets in 24 hours. *Children 6-12 years* Half to one tablet three or four times daily as required. Max. 4 tablets in 24 hours. Do not use for more than 3 days without doctor's advice. *Children under 6 years* Not recommended. Doses should not be repeated more frequently than every 4 hours. **Contraindications:** Known hypersensitivity to ingredients. **Precautions** Renal or hepatic impairment, non-cirrhotic alcoholic liver disease. Contains parahydroxybenzoates - may cause allergic reactions. **Interactions:** Domperidone, metoclopramide, colestyramine, warfarin or other coumarin anticoagulants. **Pregnancy/lactation:** Use in pregnancy [illegible] contraindicated in breast feeding. **Side effects:** Thrombocytopenia, [illegible] including skin rash, angioedema, Steven Johnson syndrome, toxic epidermal [illegible] hepatic dysfunction. **Legal category** 16's Compact: GSL; 32's: P. **Product licence number** [illegible] **Product licence holder** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, UK. **Package quantity and RSP (excl.VAT)** 16's Compact: £1.23; 32's: £2.37. **Date of revision** June 2010. Printed [illegible] of the GlaxoSmithKline group of companies.

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Pharmacy robber has sentence halved
www.chemistanddruggist.co.uk/news

In brief

PNAs consultation

LPCs must be sent a draft of their PCTs' pharmaceutical needs assessments (PNAs) in hard or electronic copy, the Department of Health has said. The DH issued a statement to clarify the consultation process, which said directing obligatory consultees to a website link would not satisfy requirements.

New therapy for COPD

MSD has announced the introduction in the UK of Daxas (roflumilast), the first orally administered selective phosphodiesterase 4 (PDE4) inhibitor to be licensed for the treatment of COPD. It is indicated for maintenance treatment of severe COPD, following authorisation by the European Medicines Agency.

Seroquel's UK approval

AstraZeneca has received UK approval for Seroquel XL (quetiapine prolonged release) as an add-on treatment for major depressive episodes in patients with major depressive disorder (MDD) who have had sub-optimal response to antidepressant monotherapy. The decision follows European Commission approval earlier this month.

Pain role proposal

Pharmacists could play an important role in pain self-management and appropriate referrals to GPs and secondary care. This is a conclusion of a report that found chronic pain management in the UK lags behind that in other western European countries. The Pain Proposal UK report was commissioned by Pfizer.

Numark discounts

Numark is offering its members discounts on a range of consumables, including fully compliant Numark controlled drugs registers that will be available from October. Discounts will be available on a range of refrigeration, counting, weighing and dispensary equipment.
www.numarkpharmacists.com

POM to P switches need GP buy-in to succeed

Bring doctors up to speed on switch process, suggests PAGB chief

Sophie Payne

Getting GP buy-in, perhaps by giving them more information on the process, will be vital to secure future prescription-only to pharmacy switches, experts have said.

The comments follow a survey of more than 1,000 UK doctors that showed only one in three want more medicines to be switched from POM to P status.

The finding was reported in OTC Bulletin following a study by doctors.net.uk. It came despite almost a quarter of the GPs surveyed saying they were asked on a daily basis to recommend OTC medicines for pain relief.

Sheila Kelly, executive director of the Proprietary Association of Great Britain (PAGB), said: "GPs complain about spending a lot of their time discussing minor ailments with patients but they get apprehensive when we suggest patients go to pharmacists instead."

Bringing doctors up to speed with the switch process could help to make them more comfortable with future switches, Ms Kelly added. "At the moment companies can't tell health professionals what they are doing to prepare for the training and information that goes along with a switch because they won't have a licence for the product," she said.

The MHRA had noted the same problem when they conducted a review of switching last year, Ms Kelly explained. "We hope to work on this to see what can be done without needing a change in the law," she added.

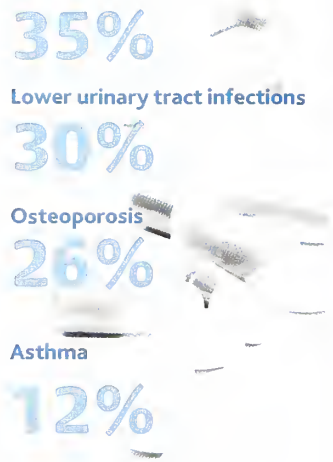
Mimi Lau, Numark's director of professional services, urged caution over switches of some products, especially those proposed for the treatment of long-term conditions.

She said the study "highlighted the need for wide consultation" before any switch.

"Without GP support they are set to fail," Ms Lau warned.

How GPs feel about switches

Percentage comfortable with POM to P switches for:



Source: doctors.net.uk survey reported in OTC Bulletin

Robot first for Scots

The robotic hospital system sends care notes to patients' community pharmacies

Scotland's first fully robotic hospital pharmacy has been opened at Forth Valley Royal Hospital.

The system automatically loads, picks, dispenses and labels medicines while the electronic e-Ward system holds patient demographics, clinical diagnosis and treatment plans.

Implementation will allow the electronic sharing of care plans between acute care and the patient's community pharmacist.

A system where the community pharmacy is sent a pharmaceutical care note when a patient is discharged is running in 70 pharmacies in the Forth Valley area.

Pharmacists using the system say it has allowed them to plan for patients with unusual doses, making ordering and accessing stock easier.

Campbell Shimmins of Woodside Pharmacy, Doune, said: "The electronic system avoids transcription errors so nothing can be overlooked and allows us to pre-empt any issues. So far the system has been seamless and the new robot in the dispensary can only make it better." **SP**

Evidence for flu jab role

The role of community pharmacy in flu vaccinations has been highlighted in Welsh national papers following a report by Public Health Wales.

The review evaluated evidence for community pharmacy delivery of vaccines in the UK, concluding the sector could play a vital in vaccinating at-risk groups.

Public Health Wales argued that successful private vaccination services showed pharmacy vaccination was popular and would be acceptable to NHS patients.

However, where patients are vaccinated in community pharmacy, there must be "appropriate and timely" communication between health professionals to ensure patient safety, the report warned. **GMA**

What's new in your PCT? Tell the C+D newsdesk
zoe.smeaton@ubm.com

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Lanes HEALTH

Kalms Night is a traditional herbal medicinal product used for temporary sleep disturbances exclusively based on long standing use as a traditional remedy.

Indications: Kalms Sleep: A traditional herbal medicinal product used to promote natural sleep Kalms Night A traditional herbal medicinal product used for the temporary relief of sleep disturbances, based on traditional use only **Active Ingredients:** Kalms Sleep: Dry extract from Valerian root (Valeriana officinalis L.) equivalent to 180mg Extraction solvent Ethanol 60%V/V – 45mg/tablet, dry extract from Passion Flower herb (Passiflora incarnata L.) equivalent to 90mg of Passion Flower herb. Extraction solvent: Ethanol 60%V/V – 16.82mg/tablet, Dry extract from Wild Lettuce leaf (Lactuca virosa L.) equivalent to 90mg of Wild Lettuce leaf Extraction solvent: Methanol 50%V/V – 22.5mg/tablet, Hop strobiles (Humulus lupulus L.) – 30mg/tablet Verbena Herb (Verbena officinalis L.) – 60mg/tablet Kalms Night Dry extract from Valerian root (Valeriana officinalis L.) equivalent to 1 5-2 5g of Valerian root. Extraction solvent. Ethanol 60%V/V – 500mg/tablet **Usage:** For oral use. Kalms Sleep Adults: Swallow 3 or 4 tablets one hour before bedtime As treatment effects may not be apparent immediately, Kalms Sleep should be taken for 2-4 weeks continuously. Kalms Night. Adults and the elderly: One tablet to be taken 30-60 minutes before bedtime. One additional tablet can be taken earlier during the evening if necessary. As treatment effects may not be apparent immediately, Kalms Night should be taken for 2-4 weeks continuously. **Side Effects, precautions & relevant contra-indications:** Kalms Sleep & Kalms Night May cause nausea or abdominal cramps. Not to be taken if allergic to any of the ingredients. Do not exceed stated dose. Not recommended for anyone under 18 years old Not recommended for use during pregnancy or when breast-feeding Contact a doctor if symptoms worsen or do not improve after 4 weeks May cause drowsiness. If affected, do not drive or operate any tools or machines. Alcohol may increase the sedative effect Excessive alcohol consumption should be avoided Kalms Night Do not take if you are taking any other medicine for sleep **PL holder:** G. R. Lane Health Products Limited, Sisson Road, Gloucester, GL2 0GR United Kingdom. **GSL. RSP:** Kalms Sleep: £3.82 for 50 tablets. Kalms Night: 21 tablets, £4 99 **PL no:** Kalms Sleep. PL 01074/0026 Kalms Night. THR 01074/0002.

Mam makes bottle-feeding easier

Mam UK has announced the launch this month of a self-sterilising, anti-colic baby bottle.

Mam Anti-Colic is sterilised by microwaving with water for three minutes, without the need for steriliser, the company says.

It also promises 80 per cent less colic due to base ventilation that ensures smooth flow.

Price: £4.49/160ml; £4.99/260ml
Pip code: 306-1199; 306-1181
Enterprise
Tel: 020 8943 8880

Market focus

- The babycare market is worth £1.36bn, growing at 8 per cent.
- Pharmacy has a 14.6 per cent share of the babycare market.

Source: Kantar Worldpanel value sales 52 weeks to January 24, 2010

In brief

Conceive Plus in Boots

Conceive Plus, a lubricant designed for couples trying to conceive, is rolling out across all UK Boots stores, distributor Forest Natural has announced. The move was due to "popular demand" since the product's launch at the end of last year, the company said.
Forever Natural UK
Tel: 01628 482571
www.forever-natural.co.uk

Party Feet

Two products and three gift packs are set to join Scholl's Party Feet range, SSL International has announced. A Beauty Cream will be added and Party Feet pads with silver flakes will be a Christmas limited editions.
SSL International
Tel: 0161 638 2000

Clarification from P&G

Following information that appeared in C+D (September 4, p25), Procter & Gamble would like to clarify that the manufacturer of the Clearblue Digital Pregnancy Test with Conception Indicator is SPD Swiss Precision Diagnostics GmbH, and it is classified as a diagnostic device.

Check out what's on TV this week
www.chemistanddruggist.co.uk/prodnews

Balancing Blooms available to independents

Flower essences range Balancing Blooms is now available to independent pharmacies.

The range has been sold through Boots since 2003, and the company has now announced extended distribution through Trinity Sales & Marketing.

To support the roll out into independents, Balancing Blooms is launching a PR and advertising campaign this month, focusing on the Calmdown! formula. The campaign will focus on the Peace formula for Christmas.

Price: £6.99/20ml
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Trinity Sales & Marketing
Tel: 01235 838590
trinitysalesandmarketing.com

Autumn colours just for men

Men's hair colouring brand Just For Men is set to return to television next week.

Manufacturer Combe International has announced £1 million support for the brand this autumn, part of a £4m investment in TV advertising this year.

The company promises further bursts of national TV exposure through to 2011.

Just For Men is available as a shampoo-in hair colour that targets grey and a brush-in gel for facial hair, both in nine shades.

Prices and Pip codes: see C+D Monthly Price List or www.cddata.co.uk
Combe International
Tel: 0208 680 2711
http://uk.justformen.com

Statement of Apology

In July this year Doncaster Pharmaceuticals (the trading name of Testerworld Limited, a subsidiary of Mawdsley-Brooks Investments Limited) published a newsletter in which it stated that Bristol Laboratories Limited had been closed by the MHRA which had created supply problems in relation to a number of products supplied by Bristol Laboratories Limited.

Doncaster Pharmaceuticals accepts that these statements were entirely untrue and it apologises unreservedly to Bristol Laboratories Limited for this error in making them.

TESTERWORLD

Shake-up for Durex range

SSL International has announced several changes to its Durex range.

Love-Box, a collection of individually designed tins for carrying condoms, are set to be launched by the brand. Each tin contains three condoms, and the launch will be accompanied by POS solutions including display cases for eight, 48 and 96 tins.

The company has also announced it has "refreshed" its mixed pack offering. The Pleasure Kit and Pleasure Pack will be replaced by Pleasure Extreme and Pleasure Ultimate, respectively, from this week. The lubrication and massage ranges have also been repackaged.

A strawberry flavour lubrication previously only available at Ann Summers will now be available through community pharmacy. The massage range will also benefit from two new products.

Prices and Pip codes: see C+D Monthly Price List or www.cddata.co.uk
SSL International
Tel: 0161 638 2000

Where is the pharmacy industry going?

Tricky question. Simple answer.

Just about anyone who is anyone in the pharmacy business is gathering at The Pharmacy Show this October. There will be more than 220 leading suppliers (the most ever), over 50 world class conference speakers, senior executives, leading regulators, top policy-makers, all the major associations and most importantly of all your industry peers, people just like you... thousands of frontline pharmacists, pharmacy executives, owners and support staff. There's plenty to talk (and learn) about. Whether it's the new frontline healthcare responsibilities facing community pharmacies, strategies and tactics for trading through challenging times or the need to source profitable new retailing ideas, you can get it all at the UK's largest source of world-class, live CPD education and the biggest sourcing event for medicines, equipment, technology, retail and services. And, remarkably, it's all **FREE**.

Go to **www.thepharmacyshow.co.uk** for the full programme and to get your free delegate pass. Or call **01926 485151**

Pharmacy Show

10th – 11th October 2010 / The NEC Birmingham

Pictured L to R: Bernard Mweseka, Pharmacy Manager, Day Lewis; Dvyesh Patel, Pharmacy Technician, MED-Chem Pharmacy; James Davies, Academic Pharmacist, London School of Pharmacy; Mike Ritson, Superintendent, ABC Drugstores; Richard Harrild, Retail Sales Manager, Lloydspharmacy; Raj Bali, Pharmacist, Lloydspharmacy; Ali Gul Ozbek, Owner-Superintendent, MED-Chem Pharmacy

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More on how rosiglitazone fell out of favour
www.chemistanddruggist.co.uk

Withdrawing from rosiglitazone

As rosiglitazone is withdrawn, leaving tens of thousands of patients in medication limbo, **Gavin Atkin** reveals the reasons why and finds out what pharmacists need to do

Rosiglitazone's withdrawal in Europe last week had a sense of sad inevitability. The history of the thiazolidinedione or glitazone family has been one of high promise and popularity with patients, but it has also been dogged by disaster.

In 1997, for example, troglitazone was withdrawn in Europe when evidence of adverse liver effects emerged after launch. And even the survivor, pioglitazone, is now under investigation in the US over suggestions it may be linked to an increase in risk of bladder cancer.

Rosiglitazone was launched in 2000, initially marketed as the single drug formulation Avandia, but later made available in combined formulations with metformin as Avandamet and with the sulphonylurea glimepiride as Avaglim.

Since then the cardiovascular issues have been particularly important in relation to rosiglitazone, with accusations that the drug causes oedema leading to heart failure, and that patients taking the drug are at increased risk of cardiovascular events.

In 2007 the European Medicines Agency's (EMA's) Committee for Medicinal Products for Human Use reminded prescribers of the prescribing regulations applying to rosiglitazone. Then, in January 2008, it tightened the rules in relation to when rosiglitazone could be prescribed.

Then two studies, published simultaneously on June 28 in the Journal of the American Medical Association and Archives of Internal Medicine, intensified things. A storm of argument followed, with articles in the New England Journal of Medicine and the BMJ, and a BBC Panorama programme focused on the secrecy surrounding the EMA's decision-making.

Then, on September 23, the EMA made its announcement: despite GSK's efforts in support of its blockbuster product, rosiglitazone was to be withdrawn in Europe, based on evidence that had come to light since an earlier review in March 2010.

The committee concluded that the benefits of rosiglitazone-containing medicines no longer outweighed their risks. Although, perhaps surprisingly, on the same day and based on the same evidence, the US medicines authorities came to a different conclusion. Rosiglitazone remains available to US doctors and patients if they cannot control their diabetes using other medications.

The RPS advice for pharmacists

- Patients should be advised not to stop treatment without first consulting their prescriber.
- Prescriptions should be discussed with patients and patients advised to make an appointment with the prescriber.
- If prescribers want to continue the medication, patients should be advised not to stop taking the medicine and to make an appointment for a review with the prescriber.

> "Patients may not go to their GP for weeks and may only find out [about the withdrawal] in the pharmacy"
>
> SIMON O'NEILL
> DIABETES UK

So what will be the impact of the EMA decision? The MHRA has set the estimated number of patients taking rosiglitazone at 90,000; other organisations have suggested 100,000, and others still more. Whatever the true figure, this is a big number of patients, and pharmacy will be one of the places the effects of change will be felt first.

"Where patients hear that the drug they are taking is being withdrawn for safety reasons and that they have to take this same drug the following morning, it can be quite concerning," Anthony Cox, Aston Pharmacy School lecturer in clinical therapeutics, told C+D.

Patient organisation Diabetes UK is relieved at the announcement following concerns that patients have been receiving conflicting information from the press. But the key information may not reach everyone at the same time, care director Simon O'Neill told C+D. "Many patients on polypharmacy are likely to be seen by prescribers once every one or two months, but some patients will have a couple of months' supply of their antidiabetic drugs and so may not attend their GP practice for some weeks. This group may only find out in the pharmacy."

Diabetes UK is also advising patients that there are a lot of good alternatives to rosiglitazone, one of which is the surviving pioglitazone with a safer profile.

Mr O'Neill says: "Whether GPs will transfer patients from one glitazone to another is not clear. There is a need for prescribers and patients to look at all options, and the newer drugs have not been on the market so long and many of them are injectable."

Datamonitor healthcare analyst Christine Henry says the glitazone class of drugs has often been the best possible type treatment for some patients, and she also anticipates patients switching from one class member to another. "They have long-term effects in some patients and are particularly useful in younger patients who are unlikely to have heart failure or fracture risks," she explains.

Others may want to steer away from the class, though, and Ms Henry predicts many patients will switch to the DPP4 class including sitagliptin (Januvia), vildagliptin (Galvus) and saxagliptin (Onglyza), as recommended by Nice as a second line.

"However, pioglitazone will come off-patent and so will be cheaper in a couple of years. It will be interesting to see how the tension between safety and cost plays out in this area," she says. And at a time when the government is desperate to cut public spending, Ms Henry raises an important point.

For more information

MHRA:
http://tinyurl.com/39pc4yb
NHS CAS:
http://tinyurl.com/2v7d5v8
RPS:
http://tinyurl.com/23htn9b

How have your patients reacted to the news?

zoe.smeaton@ubm.com

The Finance Zone

PART 9: VAT for pharmacists – accountant Richard Baker offers a quick five-step guide

If you ask most people what they know about VAT they say "17.5 per cent" (or 15 per cent or 20 per cent!). But the reality is that VAT is an extremely complicated area; here are the five most important things pharmacists need to remember:

1. Monthly not quarterly

The first tip I can give you, and I'm sure most pharmacy businesses do this already, is to register for monthly rather than quarterly VAT returns to speed up your refund.

2. Accounting for VAT on sales

Pharmacy sales are made up of items with varying VAT statuses and this makes it difficult to determine the VAT due.

It is virtually impossible for someone to remember the VAT status of all of the items that you sell (ie exempt, zero, 5 per cent or 17.5 per cent) and so you need an appropriate method to calculate your output tax (VAT of your sales).

There are specialist apportionment and direct calculation schemes depending on the size of your business. These schemes are available for all retailers to use, with further special rules for pharmacies. These schemes work on the basis of purchases and expected selling prices of items.

Richard Baker: VAT is extremely complicated so be aware of the pitfalls

If you have an EPoS system, you should not need to worry about this as your price file should be set up to deal with VAT on an item-by-item basis. But it is worth ensuring your price file is up to date.

3. Properties

If you are buying a property, you should always make enquiries regarding its VAT status. Finding out that a property is subject to VAT on the day you are purchasing it is a complication that is best avoided. As ever, it is vital to seek professional advice.

4. Locums

The issue of pharmacy locums is making news in the VAT world again. HMRC maintains that the provision of locums is a supply of staff and hence taxable, and not the provision of services by a pharmacist and hence VAT exempt. The effect of this is that if you are a locum earning more than £70,000 per annum (including expenses), then you will be required to register for VAT. You should be aware that some organisations are not used to dealing with VAT-registered locums from an administrative point of view.

The charge of VAT should not be onerous as a pharmacy will normally be able to recover it.

5. Change in VAT rate

Finally, don't forget the increase in the standard rate of VAT to 20 per cent from January 4 next year.

Richard Baker is a partner at accountancy firm Crowe Clark Whitehill

Crowe Clark Whitehill

NEXT MONTH
Staff benefits

Are we profiteering or making a living?

"SOMETIMES WE MAKE A BIG PROFIT, BUT THAT'S BUSINESS. SO WHEN IS IT PROFITEERING?"

"How much for Viagra?" used to be a question heard in the corner of dodgy pubs and clubs, but now it's a common question in our pharmacy. Ever since the supermarkets started first a price war, and now supply under a PGD, our private scripts have dried up because I'm not prepared to sell myself cheap and dispense at cost with no fee.

Never mind, maybe we'll regain some business from private flu jabs. That was a hard service to price because we don't want to be unrealistic, but we want to make it worthwhile – so £14.95 was decided. And subsequently I read a multiple is offering the jab for £9, which doesn't leave us much profit if we match that. But of course there's always the 'unlicensed special', the last bastion of a really decent return – or is it profiteering?

Ever since the Drug Tariff settled on the quixotic basic price and discount scale system of reimbursement, pharmacy has been a balance of profit and loss – we know when we dispense on some prescriptions we lose, and on some we gain. Sometimes we make a big profit, but that's business. So when is it profiteering? When an optician buys a pair of frames for £15 and sells them for £150? When a supermarket puts 20p worth of veg in a shiny tray with flavoured butter, marks it 'Fine Dining Range' and sells it for £3.99?

The NHS, however, thinks specials pricing is not only profiteering but fraud, although a year's investigation was unable to prove "intentional deception". Despite that, someone decided pharmacy should be smeared in the media as profiteering fat cats when the specials pricing story was spun last week to the BBC.

When are we going to learn we can't expect a proper funding package if, on one hand, we say "we can afford to dispense scripts at cost, for nothing, and we'll provide our life-saving vaccination service at a third off!" and, on the other, say "it's OK to charge the NHS £1,500 for £1.50 worth of generic crushed up in a bit of water". That is saying we're making so much profit from the NHS we don't need to charge our private customers.

Even our 'pharmaceutical services' trump card is suffering from the pressure to carry out more and more MURs, resulting in increasing questions over their value, and if they are scrapped that money won't come back to pharmacy. So all of us – independents and multiples – must show that we need a reasonable remuneration for a valuable quality service, both private and NHS business.

Unless we change, the DH will continue to squeeze what it sees as its only financial control – category M. Then someone really will be profiteering from pharmacy – the government!

Is pharmacy in danger of undercutting itself out of existence?

haveyoursay@chemistanddruggist.co.uk

Pharmacy now has to evolve to survive

Pharmacy minister Earl Howe commented on the healthcare white paper by saying the government wanted "community pharmacists to expand the range of clinical and public health services they deliver and to help patients get the most from their medicines and to better manage their conditions".

At the time this was widely applauded as a rallying call for the pharmacy profession and a roadmap for developing the sector.

The further financial strain placed on pharmacy as a result of the latest £140 million category M clawback means some creative thinking will be required to deliver this aspiration.

The subsequent Bow Group report identifying enhanced services as a cost-effective yet underutilised resource that could be funded through Cat M clawbacks is a welcome input in developing a solution, as is the recommendation that pharmacists are rewarded through a QOF.

If pharmacy is to play a core role in the new vision for the NHS and to help GPs and hospitals deliver better health outcomes, then there has to be an incentive to make the investments necessary to improve community pharmacy services.

Studies have suggested only around half of all medication is taken correctly by patients and ensuring medication is correctly dispensed and managed is key to maintaining patient welfare and ensuring the NHS drugs bill is used effectively.

It is also critical to ensuring patients benefit from the medication they are prescribed and gain the intended health outcomes. This role of medicine usage is a spine from which many pharmacy services can be hung from in the future.

A thriving network of community pharmacies can achieve these goals. But pharmacy can do far more and can play a much greater role in promoting better healthcare and preventing illness.

Huge investments have been made by community pharmacies in providing a range of primary care services. It is hoped pharmacy's role in this arena will be clarified in the awaited 'public health' white paper.

When it comes to saving money, the average consultation with a community pharmacist is more than £14 cheaper than a comparable consultation with a GP. For GP consortia looking to deliver cost-effective healthcare and achieve better health outcomes, a well-resourced community pharmacy can be a valuable partner.

What's needed now more than ever is evolution of the pharmacy contract supported by sustainable funding, driven by incentives and underpinned by quality. As we strive to evolve and fulfil our potential in the new NHS, we need to ensure we are not once again overlooked – but we have to deliver.

Andy Murdock, pharmacy director, Lloydspharmacy

"A WELL-RESOURCED COMMUNITY PHARMACY CAN BE A VALUABLE PARTNER FOR A GP CONSORTIA"

Update

Your weekly CPD revision guide

60-second summary

Inflammatory bowel disease (IBD) is a term that covers ulcerative colitis (UC) and Crohn's disease. This CPD article outlines the progression, pathology and complications of these chronic, progressive diseases, and discusses how they present and are diagnosed.

What are the risk factors?

There is a small genetic link, with around 25 per cent of patients having a history of bowel inflammation. Acute stress can play a major role in triggering relapses. Smoking has contradictory effects; smokers are more prone to Crohn's than non-smokers, but are less prone to UC. Environmental factors such as diet and lifestyle may play a role.

How does IBD present?

Patients with IBD present with non-specific symptoms, such as severe diarrhoea, abdominal pain, cramping, fever, anorexia, nausea and vomiting. Symptoms tend to be of long duration and fail to respond to treatment. Patients with severe diarrhoea of more than 24 hours' duration should be referred to a GP. Other features include very frequent bowel movements with stool consisting of little more than blood, mucus and perhaps pus, malaise, and weight loss.

Inflammatory bowel disease: pt1

The clinical features of ulcerative colitis and Crohn's disease, the two chronic diseases covered by the term inflammatory bowel disease

Russell Greene MRPharmS

Inflammatory bowel disease (IBD) is a collective term covering two chronic diseases that mainly affect the GI tract. It affects one in 500 people in the UK and is characterised by progressive damage to the gut wall, usually in the large and/or small intestine, with resultant abdominal pain, diarrhoea and eventual deteriorating function.

Although IBD is mainly a disease of the bowel, there can also be serious inflammatory damage to other tissues, such as the eye and the joints.

IBD consists of Crohn's disease and ulcerative colitis (UC), the former being the more serious. Crohn's can affect any part of the gut, progresses faster than UC, is more likely to have serious complications and is more resistant to treatment. Patients with Crohn's tend to have poorer outcomes. By contrast, UC is generally less debilitating. It is restricted to the rectum and colon and fewer patients are seriously ill for long periods. It also affects an older group of patients than Crohn's. See table 1, page 18, for a comparison of the clinical aspects of the two conditions.

Causes and risk factors

As with most autoimmune diseases, IBD has some genetic links, but these are not strong: about 25 per cent of patients have a family history of bowel inflammation, and the concordance rate for identical twins is about 35 per cent for Crohn's and 10 per cent for UC.

Certain HLA (histocompatibility) genes predict a predisposition to IBD, and there is overlap with other autoimmune conditions. For example, HLA-B27 is found in IBD and ankylosing spondylosis.

It is currently believed IBD is caused by a fault in immune recognition, which persuades the body to mount an inflammatory-immune response to gut tissues. This is commonly associated with or triggered by an intestinal microbe, such as the measles virus. However, the precise connection of microbes to the disease process is uncertain.

Other aetiological factors for IBD have been sought but no unequivocal influences have been found. Industrialised countries have the highest rates of IBD, which are increasing in these areas. Certain ethnic groups have different prevalence, for example Crohn's is more common among people of Jewish descent. Dietary and other lifestyle factors have also been implicated, with prevalence changing following migration to another area suggesting environmental factors.

Acute stress can play a major role in triggering relapses. Smoking has contradictory effects; smokers are more prone to Crohn's than non-smokers, but are less prone to UC. Both genders are equally affected.

Crohn's and UC can both start in early adulthood, although patients with Crohn's tend to be younger. A further cohort of patients can suffer their first UC attack in middle age.

Pathology

In Crohn's disease the entire thickness of the gut wall is affected, with inflammatory swelling significantly reducing the gut lumen. In severe cases this can lead to intestinal obstruction. Inflammatory lesions can occur simultaneously in various parts of the gut, and appear anywhere from the mouth to the anus, although in 95 per cent of patients only the small and/or large intestine is affected. These discontinuous disease areas are referred to as skip lesions.

In UC usually only one, continuous, strip of gut is affected, most commonly either in the rectum or the distal (sigmoid) colon. Inflammation is restricted to the gut lining, so obstruction is not a problem. Indeed the opposite, toxic megacolon, is a potential complication.

Signs and symptoms

The classic features of an acute IBD attack or exacerbation may superficially resemble nonspecific abdominal upset, gastroenteritis or acute abdomen, with severe diarrhoea, abdominal pain, cramping, fever, anorexia, nausea and vomiting.

Key features to look for when a patient first presents with IBD include the duration and chronicity of the condition, and failure to respond to standard non-specific remedies. Patients who present with severe diarrhoea of more than 24 hours' duration should be referred to a GP. Other features include very frequent bowel movements

Table 1. Comparison of ulcerative colitis and Crohn's disease

	Ulcerative colitis	Crohn's disease
Most common site	Sigmoid colon/rectum	Anywhere in gastrointestinal tract Mainly terminal ileum/colon
Pathology	Epithelial inflammation	Transmural inflammation
Aetiology	Autoimmune	Autoimmune
Age range	Onset usually in 20-40 years or 50-70 years	Onset usually in younger patients
Severity/effect on life	Many patients can live normal lives most of the time	Severely affects life of most patients
Relapses	May not be frequent	Frequent
Complications – GI	Dehydration, fluid/electrolyte imbalance Megacolon; colon cancer	Malabsorption Obstruction, perforation, fistulae, colon cancer
Complications – extra-intestinal	Arthritis, spondylitis, iritis, uveitis, hepatitis, dermatitis	Arthritis, spondylitis, iritis, uveitis, hepatitis, dermatitis
Management	Drugs and possibly surgery; stoma	More intensive drug therapy; surgery more common; stoma

(often more than 10 times daily) with stools consisting of little more than blood, mucus and perhaps pus; malaise; and weight loss. Crohn's is usually more insidious in onset, and is associated with greater weight loss than UC.

Diagnosis

Blood tests in a patient with IBD will reveal typical signs of systemic inflammation, with a raised erythrocyte sedimentation rate (ESR) and plasma C-reactive protein.

There will also usually be anaemia, perhaps exacerbated by iron deficiency from malabsorption and anorexia. In Crohn's, malabsorption may also cause hypoalbuminaemia and possibly hypovitaminosis (eg folate, B_{12}).

In either disease, severe and prolonged acute attacks of diarrhoea may cause dehydration, with reduced blood pressure, tachycardia and possibly hypokalaemia. Other tests required include liver function tests and stool examination for pathogenic microbes and blood.

The definitive diagnosis of IBD relies on imaging. For colonic disease, a barium enema or colonoscopy/sigmoidoscopy is standard. If disease in the ileum is suspected, access is more difficult as colonoscopes cannot penetrate further back than the caecum. Similarly, duodenoscopes cannot penetrate very far along the ileum from the stomach.

Alternatively, a barium meal with follow-through can be used, where a radio-opaque test meal is followed radiologically for an extended period. Areas affected by Crohn's will show up as a grossly narrowed lumen (called the 'string sign'). It is also possible to inject radio-labelled leucocytes and scan the patient for hotspots, because inflammatory cells will concentrate at sites of inflammation.

CT and MRI scanning may also be used. Otherwise, laparotomy may be needed, using modern keyhole techniques to inspect the abdomen directly with an endoscope. Endoscopy also allows tissue samples to be taken for biopsy, which may help in identifying inflammatory cells or possible neoplasia.

An emerging technique is capsule endoscopy. In this a miniaturised video camera is fitted inside a capsule small enough to be swallowed. It transmits pictures of the interior of the gut wirelessly at intervals, until expelled in the faeces. This technique can be used when all other tests have failed to locate a lesion, but it is expensive as the instrument is not reusable.

The course of IBD

IBD is a chronic progressive disease characterised by relapses and remissions. In about 10 per cent of patients the disease remits permanently, while about 20 per cent of patients progress to severe disease, with almost continuous ill health and the eventual need for surgery.

However, most patients with UC experience long periods of relatively normal health, although they usually require maintenance therapy. Life expectancy is not significantly reduced, and the effect on work may be minimal.

Crohn's tends to follow a more debilitating course, with a greater proportion of sufferers experiencing prolonged ill health, more frequent relapses and hospital admissions, and greater weight loss. Life expectancy is slightly reduced.

Up to three quarters of Crohn's patients will need surgery. However, surgical excision of one or more problem areas (with rejoining of the gut) rarely solves the problem; the disease tends to subsequently flare up again elsewhere in the gut. Because frequent operations have a cumulative risk and a progressively debilitating effect in themselves, surgery is delayed as long as possible. On the other hand, surgery for UC patients may be practically curative, although it may leave the patient with a stoma.

Complications

In UC, sudden gross swelling of the colon (toxic megacolon), often associated with infection, may occur. This may cause perforation of the intestinal wall and resultant peritonitis.

Crohn's disease tends to cause more frequent intestinal perforation than UC, because although the GI wall is thickened in the condition it is insubstantial and has deep, ulcerated clefts. It therefore tends to cause fistulas through to other intestinal organs, such as the bladder, or even through to the surface of the abdominal wall. Perforation and abscesses are also quite common, and obstruction can occur.

These should be considered a medical emergency requiring surgery.

Both Crohn's and UC predispose patients to colon cancer after about 10 years, especially if the condition is poorly controlled. Therefore regular screening is necessary.

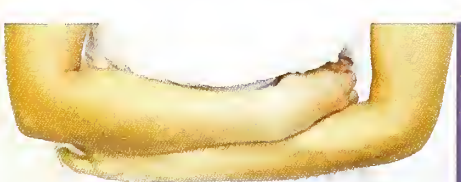
There are also possible extra-intestinal inflammatory complications that may affect patients with Crohn's or UC. These include limb joint arthritis (up to 20 per cent of patients), spondylitis, iritis, hepatitis and dermatitis. These may either follow the course of the underlying disease, or follow an independent course (and may be the cause of first presentation).

Russell Greene MRPharmS is a pharmaceutical writer and consultant, and former senior lecturer in clinical pharmacy, King's College, London

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p19).

Further reading

- Baumgart DC, Carding SR. Inflammatory bowel disease: cause and immunobiology. Lancet 2007; 369:1627-40
- Baumgart DC, Sandborn WJ. Inflammatory bowel disease: clinical aspects. Lancet 2007; 369:1641-53
- Greene RJ, Harris ND. Pathology and therapeutics for pharmacists. A basis for clinical pharmacy practice. 3rd edn. 2008 London: Pharmaceutical Press.



NEXT WEEK
IBD part 2: medical management of Crohn's and ulcerative colitis

Inflammatory bowel disease: part 1

Plan

Act

Evaluate

What are skip lesions? In UC which parts of the gut are most likely to be affected? Why is surgery delayed for as long as possible in Crohn's disease? What are the complications of UC?

This article describes ulcerative colitis and Crohn's disease and how they differ. It includes information about causes and risk factors, pathology, symptoms, diagnosis, disease progression and complications.

- Read more about Crohn's disease on the Patient UK website at http://tinyurl.com/crohns01.
- Read more about ulcerative colitis on the Patient UK website at http://tinyurl.com/colitis01.
- Find out more about the investigations used in the diagnosis of IBD from the Crohn's disease and ulcerative colitis sections of the crohn's.org.uk website at http://tinyurl.com/crohns02.
- Learn more about the complications that can occur in IBD, including arthritis and ankylosing spondylitis, from the Crohn's disease and ulcerative colitis sections of the crohn's.org.uk website at http://tinyurl.com/crohns02.
- Find out more about the links between IBD and cancer from the National Association for Colitis and Crohn's website at http://tinyurl.com/colitis02.

Are you now confident in your knowledge of IBD including the differences between Crohn's disease and ulcerative colitis? Are you familiar with the investigations used and the complications that can occur?

5 minute test

What have you learned?

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Step 1

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Step 2

Access the 5 Minute Test questions on the C+D website at www.chemistanddruggist.co.uk/mylpd

Step 3

Use your PIN to complete the assessment online. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will be able to download a CPD log sheet that helps you complete your CPD record at www.pdadiary.com

Registering for Update 2010 costs £37.60 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 0207 921 8425.

Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

Hormone replacement therapy

On her day off Hannah, senior medicines sales assistant at the Update Pharmacy, has met up with her friends Barbara, Lisa and Maria in a coffee shop. The conversation gets round to getting older.

"We'll be coming up to the change before too long," Barbara says, "I don't want to go through all those years of nasty hot flushes, getting tetchy, going off sex and starting to look old and wrinkly. I'm going on to HRT as soon as I get the first inkling, and I'll stay on it till I die if I can."

"I'm very doubtful about HRT," says Lisa, "I'm not sure it's safe. I know that a few years ago women were being warned against it because it was supposed to increase the risks of breast cancer and heart disease. I'm just going to take lifestyle measures and see how they work."

Maria chimes in: "I've seen articles and ads about herbal natural treatments for HRT. They should be worth a try – at least they're not going to do you any harm."

"Hannah," says Barbara, "you haven't said anything yet. You work in a pharmacy, what do you think?"

Hannah replies: "To be honest, I really don't know. Why don't we ask our relief pharmacist Lydia to our next get-together? I'm sure she'll be able to sort out the issues for us."

Questions

1. What is the most recent thinking on the benefits and risks of HRT?
2. Which lifestyle measures are thought to help reduce menopausal symptoms?
3. How effective are complementary medicine treatments considered to be?

Answers

1. A review by an international expert panel assessed the overall benefits and risks for women taking HRT for five years.[1] Areas of benefit included relief of hot flushes and symptoms of urogenital atrophy and prevention of fractures and diabetes. Risks included venothrombotic episodes, stroke, and cholecystitis. For women starting HRT between ages 50 and 59 or less than 10 years after onset of menopause, additional benefit included reduction of overall mortality and coronary artery disease. Beneficial effects on colorectal and endometrial cancer and harmful effects on ovarian cancer occurred but affected only a small number of women. Findings of a study[2] that suggested an increased risk for heart disease, stroke, and breast cancer, were considered not to be appropriately applied as the average age of women participating in it was 63.

2. Regular aerobic exercise such as running or swimming, avoiding possible triggers such as caffeine, alcohol, smoking and spicy food; wearing lighter clothing and sleeping in a cooler environment, and controlling weight.

3. There is no good evidence that phytoestrogens, black cohosh, evening primrose oil, dong quai, ginkgo biloba, or ginseng, or other complementary or alternative therapies are effective for treating menopausal symptoms.[3] Concerns have also been raised about their safety. The British Menopause Society has also issued a consensus statement discouraging their use.[4]

References

1. Santen RJ, et al. Postmenopausal Hormone Therapy: An Endocrine Society Scientific Statement J Clin Endocrinol Metab. 2010 Jul 14. [Epub ahead of print]
2. Writing Group for the Women's Health Initiative Investigators(WHI). Risks and benefits of oestrogen plus progestin in healthy postmenopausal women. JAMA 2002; 288: 321-33.
3. Menopause. Clinical Knowledge Summaries (www.cks.nhs.uk/menopause)
4. Alternative and Complementary Therapies, British Menopause Society Consensus Statement (June 2007).

Preparing for winter

Winter is on its way and colds are just around the corner, so make sure you're ready

Some 15 million people in the UK are affected by cold viruses each year.[1] There are over 200 common cold viruses, so they are difficult to avoid. On average adults get between two and five colds a year, while children get between seven and ten.[2]

The first signs of a cold include coughing, sneezing , blocked or runny nose, sore throat or headache. For most people with a cold, the local community pharmacy is their first port of call for advice and over the counter medicines to manage their symptoms. The cough and cold market typically peaks from November through to the end of February. Now is the time to stock up with the right products and display them in your pharmacy effectively so you can maximise your sales this winter!

10 Top tips on advising customers on cold products this winter

1. Provide a choice – make sure you stock a range of cold products so that your customers have choice. If you have an electronic point of sale system (EPoS), use this to identify the more popular cold products you sell. Also check the media to see what cold products are being promoted each week… your customers are likely to come and ask for a particular product that they have seen advertised.

2. Display your cold products in sections – create a cough and cold destination in store which not only creates impact, but may also encourage customers to buy the most appropriate product for their ailment. A customer may come in to your pharmacy just to buy a cough medicine, but may also need a nasal spray and some throat lozenges and would therefore buy these when they see them displayed together. When buying more than one product, we advise customers to always read the label. Although customers should not be able to self-select P medicines, you could consider displaying dummy boxes of P cold medicines in your GSL section to raise awareness of the range of products available in the pharmacy.

3. Consider product placement – think about where you place your products on your shelves. Products placed at eye-level tend to have the highest proportion of sales while those on the bottom shelves have the lowest proportion of sales.

4. Think about link sales – displaying non-medicine products associated with colds, such as tissues, in the same section as medicines may prompt customers to buy them and increase your sales.

5. Use the end of one of your gondolas to promote cold products – gondola ends are key promotional areas where you can create visual impact using only a few different types of related products.

6. Clearly identify your cold products – use signage and point of sale display materials to mark the areas where your cold products are displayed. If products are clearly displayed then customers can easily find the product(s) they are looking for and that best treat their symptoms.

7. Create a seasonal window display – use your pharmacy window to promote cold medicines. Make sure your display is bold to attract customers' attention and draw them into your pharmacy. Change your display regularly during the winter – if you have the same display all winter, it will lose its impact – your regular customers won't notice your display after they have seen it a few times!

8. Good housekeeping – make sure your displays are clean, tidy and well stocked.

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Your customers are less likely to see the benefit of the products and as a result will be less likely to purchase them from a display that looks dusty, untidy or cluttered.

9. Train your staff – make sure all your staff are familiar with the range of products available to manage the symptoms of colds and are able to provide appropriate advice. Your pharmacy staff are your biggest asset when it comes to maximising your sales!

10. Promote your pharmacy – make sure your customers see your pharmacy as their first port of call when they need advice about colds. Think about advertising your pharmacy in local media or leaving some of your pharmacy leaflets in public places such as your local library and GP surgeries. You could also use 'Ask Your Pharmacist Week 2010', which is taking place from November 8-14, to raise awareness of your role as a frontline provider of healthcare.

Vicks has been helping relieve the symptoms of colds for many years. This winter, Vicks will be running extensive consumer and pharmacy marketing programmes for Vicks First Defence Nasal Spray and Vicks Sinex Soother, as well as focusing on pharmacy education for Vicks Cold & Flu Care Medinite Complete Syrup.

Vicks First Defence Nasal Spray
... helps stop a cold in its tracks!

- Vicks First Defence Nasal Spray is the ONLY non-prescription product clinically proven to help stop a cold before it develops!
- Using Vicks First Defence Nasal Spray within 24-36 hours of cold warning signs helps fight the cold virus where it starts – at the back of the nose, effectively stopping it developing and spreading

Vicks First Defence Nasal Spray is unique and works in three ways:

1. **TRAPS** – the viscous Micro-Gel flows to the back of the nose and throat, where it traps the cold viruses
2. **INACTIVATES** – the low pH of the Micro-Gel inactivates the cold viruses
3. **REMOVES** – the spray irrigates the site of infection and the Micro-Gel's ingredients stimulate mucus secretion – thereby helping to flush out the trapped disarmed viruses

Vicks Sinex Soother

- Vicks Sinex Soother is a convenient nasal spray, which contains a powerful decongestant
- Vicks Sinex Soother can relieve congestion even if a cold has already taken hold
- Always advise customers to read the label

Vicks Cold and Flu Care Medinite Complete Syrup

- One of the worst things about having a cold can be trying to get to sleep
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Abbreviated Prescribing Information: Vicks Sinex Soother: [illegible] 0.5mg/ml For local symptomatic relief of nasal congestion [illegible]. Adults and children over 12: One or two sprays up each nostril to a maximum 2-3 times daily Caution: [illegible] for more than 7 consecutive days Use with care in those with hypertension, severe cardiac [illegible] hyperthyroidism and diabetes mellitus 15ml £3.99 Vicks Cold & Flu Care Medinite Complete Syrup (P): Green [illegible] containing [illegible] phenylephrine hydrobromide 15mg, pseudoephedrine hydrochloride 60mg, doxylamine succinate [illegible] and paracetamol 500mg in each 30ml dose Night-time cold medicine Adults and children over 12 years: [illegible] bedtime Caution: May cause drowsiness. If under the care of your doctor, receiving any prescribed medicines, or pregnant, consult your doctor before use. Contains alcohol Patients should not take other paracetamol-containing products concurrently Use with caution in severe renal or hepatic impairment and in those with non-cirrhotic alcoholic liver disease, where hazards of overdose are greater 180ml £4.49
References: 1. www.nhs direct nhs.uk 2. www.nhs.uk/livewell/coldsandflu

4 reasons to attend The C+D Conference at the Pharmacy Show

Jennifer Richardson reveals why this year's C+D Conference programme, featuring some of the biggest names in community pharmacy, is not to be missed

1 Find out how the RPSGB split will affect you

In the wake of this week's official split of the RPSGB, and the launch of new regulator the General Pharmaceutical Council (GPhC), GPhC chief executive Duncan Rudkin is set to reveal what will change in regulation and how it will affect you. And Helen Gordon, chief executive of the new Royal Pharmaceutical Society (RPS), will explain how it will "look, feel and act differently to make sure all pharmacists can look forward to feeling that their professional body is in tune with their aspirations for the future".

2 Discover how to get a fair Stat Comm hearing

With regulation high on the agenda, David Reissner, head of healthcare and partner at Charles Russell solicitors, will be explaining how you can ensure you get a fair hearing if you are accused of doing something wrong, including:

- the most stupid thing you can say to a police officer or GPhC inspector
- when you should say "I made a mistake, I'm sorry" – and when you shouldn't
- what to do if you're accused of doing something wrong more than six years ago
- what happens if you fail to declare past convictions and investigations.

3 Get to grips with funding

"Pharmacists are now having to deal with a new paradigm in healthcare," says Ms Gordon. "The financial squeeze will be felt both within the NHS and by those who contract to it, and pharmacy will be under scrutiny as never before."

PSNC chief executive Sue Sharpe will use her speaker slot at the C+D Conference to explain the implications of this situation for pharmacy in the context of the current contract and the ongoing cost of service inquiry.

In addition, AAH managing director Mark James will discuss how current trends and future developments could impact your pharmacy's bottom line, and BGMA chairman Michael Cann will bust "the category M myth". Mr Cann says: "Pharmacists need to engage with the reality of how reimbursement of category M affects them, and how their choices then affect the stability and return they experience from the system."

4 Learn from the experience of others

There is no such thing as a new idea, runs the oft-quoted expression. Anyone who's seen the constant innovation in pharmacy services might disagree, but pharmacy could also benefit from better sharing of best practice. As Rowlands Pharmacy managing director Kenny Black says: "I'm particularly interested in new initiatives that provide insight into how people are driving forward to professional and commercial agendas."

He and Co-operative Pharmacy business development director Chris Brooker will be sharing their companies' experiences. Mr Black promises "an honest reflection on where Rowlands was", and to explain "how market developments on both the prescriptions and OTC side of the business have driven changes in the Rowlands Pharmacy care experience" and how it has engaged its staff and customers.

Speakers and delegates on why you should attend

"Conferences represent a very important way of enhancing professional ability. They offer the opportunity to hear first-hand from experts in your profession, to meet with your peers, and to learn about new developments that may affect your professional practice. Conferences give us the chance to consider topics we may not encounter daily."
Duncan Rudkin, chief executive, General Pharmaceutical Council

"Pharmacy events can be an excellent way to get up to speed with what is going on, both in and outside the NHS."
Sue Sharpe
chief executive, PSNC

"I don't have time to go to many industry events but I think they would be worthwhile.

"If I had the time I would go. I think they would be very useful for networking and to build your knowledge."
Aina Osunkunle
K and A Pharmacy, Gateshead

"I am going to be presenting at the Pharmacy Show this year. I think it is a great exercise for networking for people at all levels. In the past I have taken my pre-regs along to attend the relevant programmes for their level."
Brian Deal
Ashwell Pharmacy, Hertfordshire

One week to go! Don't miss out: sign up for your free ticket to the C+D Conference on October 10 and 11 at the Pharmacy Show now

www.chemistanddruggist.co.uk/thepharmacyshow

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on industry events

REFLECT	Consider how attending industry events could benefit my knowledge and practice.
PLAN	Decide which areas of my knowledge and understanding of the sector I need to improve and which industry event(s) could help.
ACT	Attend relevant industry events.
EVALUATE	Have my knowledge and understanding of the sector improved?

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Career ladder

...at Alphega Pharmacy UK

Alliance Healthcare's virtual chain Alphega Pharmacy UK has expanded its management team with three appointments.

Ian Nicol takes on the role of business mentor following more than 20 years' experience in retail. Mr Nicol worked in the glass and china sector before joining Alliance Pharmacy where, as head of rebrand prior to the merger with Boots UK, he oversaw the rebranding and installation of consultation rooms in over 280 stores, and the complete refit of more than 40.

Sally Johnson becomes Alphega Pharmacy marketing consultant, after 15 years' experience in marketing. She worked at Parker Pens before moving into pharmacy, and she has worked at Avicenna and Richmond Pharmacology.

And Rachel Marchant joins the team as pharmacy consultant with over 14 years' experience in community pharmacy as a qualified pharmacist. She is a director of training consultancy Scientia Skills, and an NCAS assessor.

...at Fortuna Healthcare

North London-based independent wholesaler Fortuna Healthcare has made two senior management appointments "to reflect its ongoing commitment to expansion in the pharmacy sector".

Martin Swaine has been promoted to national field sales manager and is tasked with getting "maximum exposure" of the company's product range through its 20 area sales managers throughout the UK.

Paul Brunt joins Fortuna Healthcare as financial controller, heading up its finance department.

Fortuna Healthcare has recently been awarded an Investors in People accreditation, and has been recognised locally for its commitment to charitable causes.

...at AstraZeneca

AstraZeneca has appointed a new head of supply chain. Practising pharmacist Sital Kotecha joins the pharmaceutical giant from Accenture, where he worked with several manufacturers on pharmacy supply projects. Former head of supply chain Jonathan Bracey will be managing a UK sales region for AstraZeneca.

CAREERS

My pharmacy life

Phoenix business development manager John Preston tells **Ben Jones** about his move from community to wholesaling

John Preston: relationship management role offers variety and responsibility

My job, primarily, is to manage the relationship that wholesaler Phoenix has with the big pharmaceutical companies, so it's a bit of an end-to-end job. So we get about kind of prospecting for deals, then negotiating the details of any deal that is done, and taking that through to manage the ongoing relationship.

This was a very new department when I joined in January 2009; it had only existed for six to nine months. My job is very, very varied – a lot of my time is spent out of the office meeting with my pharmaceutical manufacturer customers. Some meetings are done by teleconference but a lot are face-to-face, because it's about relationships and the opportunity to develop them.

I get up at 6am and I don't do breakfast because that would mean I would have to get up even earlier. If the commute is reasonable I can get to work in an hour. I'm normally in the office by 7.50am.

For lunch, I usually grab a sandwich. In fact, that gives great amusement to my colleagues because they think I should be able to make a sandwich myself.

I'm contracted to leave work at 5.15pm and I like to try and leave by 5.30pm, but it depends what is going on here.

We spend quite a lot of time developing documents for clients in terms of the tender process and the information that they might need for that. We also do a fair bit of actual analysis on the results of the relationships we already have in place, to make sure they are working for both parties.

My favourite thing that I enjoy is responsibility and the strategic needs of the job; the negotiations we are involved in affect the direction of the organisation, if that makes sense.

I'm motivated by success and seeing the results of good efforts. This is the job I enjoy most of all the jobs I've done. I enjoy the diversity of the job, and I'm proud of the progression I've made to get here.

I used to be a pharmacist and I do miss the contact with patients. I've got my MUR certification and I really do enjoy MURs, so that's probably what I miss most about being a coalface pharmacist. I'd never say never, but I don't see myself going back to it.

I used to help out my dad at his pharmacy in Scotland, but I couldn't decide whether to do medicine or pharmacy because I had a place to do both. In the end, I plumped for pharmacy and I enjoy what I do now so I suppose it was the right decision. I studied at Strathclyde and did my pre-reg in Hamilton.

I've been married to Melanie, a pharmacist with Blackpool PCT, for just over 11 years and we have an 11-week-old daughter, Eve. It's our first child and it's been a shock to me quite how tired you can be, so you can guess what keeps me awake at night!

I don't have any regrets about my career so far. You can always look back and think, "What if I did this?" or, "What if I did that?" but, overall, you make the best decisions that you see at the time. If you didn't do that, you wouldn't do other things, so there's always a stage in your career where you find yourself doing a job which you think is less enjoyable than other jobs, but that leads to something else.

I certainly aspire to a more senior management role. I enjoy working for the organisation that I'm with just now so it would be good if that role was here. I suppose years ago I had very clear plans for what I wanted to do for the next five years, but my experience has told me that actually there's very little point in making those because you can't predict what is going to happen in the next five years.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on career development

REFLECT	Do I know how I want my career to progress?
PLAN	Consider how I would like my career to progress over a set time period, say five years.
ACT	Decide the individual steps needed to achieve this progression and discuss with my manager.
EVALUATE	Do I know my career goals and how I am going to achieve them?

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COURSES

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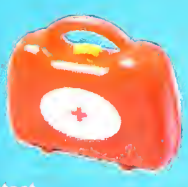

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Postscript...

Rowlands is a good neigh-bour

Rowlands Pharmacy staff spent a day building a new paddock for horse rescue centre Clip Clops as part of their ongoing commitment to charities.

The paddock was built to give children from disadvantaged backgrounds the opportunity to ride the rescue ponies at the charity's site in Mickle Trafford, the company says.

Rowlands operation head David Young took part in the day and says: "At Rowlands we are competitive and we also enjoy the idea of doing useful projects for the community. It's what we are all about."

He told C+D the day was a challenge and described how events unfolded: "The challenge seemed impossible to begin with – the site was large, the terrain was difficult, the tools were incomplete and no one had ever built a fence before and it was muddy and raining!

"The first post took an hour. We had 40 to do, plus cross bars within a seven-hour time frame."

However, the team succeeded in turning an unused site into a paddock. Mr Young adds: "Tired and exuberant we celebrated our success with champagne as true champions!"

C+D reader of the week

Meet pharmacist Emily Jones, who would like to go back in time to ancient Egypt

Who would be your ideal dinner party guest? Ricky Gervais, Stephen Merchant, Karl Pilkington or Sarah Green.

What pharmacy service would you like to see? I think making the contraceptive pill available from pharmacies would be very positive.

If you could go back in time, where would you go? I would like to go back to ancient Egypt and experience the wonder and magic of that extraordinary era.

If you weren't a pharmacist, what would you be? Something relating to fashion and design, or a journalist.

What's the secret to being a great pharmacist? Diligence, a broad smile and thick skin.

How would your family describe you? Determined, quirky and happy.

If someone gave you £1,000, how would you spend it? I would use it to travel in our VW Camper around Europe.

Can you tell us a joke? What bees make milk? Boo-Bees. What's the wife of a hippie called? Mississippi.

What's your guilty pleasure? Espresso Martinis and milk chocolate.

What's the smartest idea you've ever had? Windows 7 was my idea.

What question should we ask our next reader of the week? What would you do if you knew you could not fail?

Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk

The Victorian Pharmacist

"Why the world should be so opposed to women is hard to understand"

Sir,

It has come to my attention that there has been a great deal of discussion regarding the employment of females in the trade. A college of pharmacy for women has been established in Louisville, US, and a graduate, Miss Fauntine Vetter, made a forcible defence of the right and reason of herself and her associates in choosing pharmacy as their occupation.

Boys and young men, she urged, were with difficulty confined within four walls, and could not enjoy the seclusion of a drug store. But women, "quiet and gentle by nature, loving the privacy of the home", hail that seclusion with delight.

Why the world should be so opposed to women is hard to understand. The profession is a noble one – the pharmacist stands between the physician and the suffering of humanity. The little parcel which he sends out may bring joy or happiness, or sorrow and woe, to a household. Has any work more responsibility attached to it? Who is the nurse that soothes and administers? Is it not a woman? And if a woman can administer the decisive dose, why can she not prepare it?

Miss Vetter does not see why men, and certainly not women, should object to being served by a woman who knows her business. The perfect adaptability of women to work which requires close confinement, steady habits and deft fingers should at once guarantee her success. Furthermore, women will not be influenced by the temptations so often destructive to men.

Verily, perhaps ladies of virtue are worthy of something better than pharmacy.

The Victorian Pharmacist's comments are from 1884, when the idea of equal rights was scoffed at. Fortunately times have changed, thanks to the likes of Fauntine Vetter. If you have a subject you want the Victorian Pharmacist to cover, email postscript@chemistanddruggist.co.uk.

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Sunday, October 10

12.30pm
The five biggest challenges facing pharmacy and what the Society will do to help you
Helen Gordon, chief executive, the RPS
As the RPSGB returns to its roots as the leadership body for pharmacists, its new chief executive reveals how the Society will steer pharmacists to a more rewarding professional future

1.10pm
How your life will change under the new pharmacy regulator
Duncan Rudkin, chief executive, General Pharmaceutical Council
Pharmacists have a new professional regulator but will it just lead to tougher sanctions or will the promise of 'light touch' regulation become a reality? The GPhC's Duncan Rudkin reveals what the profession's new disciplinarian will mean for you

1.50pm
The inside track on stat comms and what pharmacists have to do to ensure they get a fair hearing
David Reissner, head of healthcare, Charles Russell solicitors
With community pharmacy now facing more scrutiny than ever before, David Reissner looks at what you should do if you're investigated and the sanctions you could face from the GPhC and PCTs

2.30pm
Pharmacy contract funding – a behind-the-scenes account of where we are and what the future holds
Sue Sharpe, chief executive, PSNC
PSNC chief executive Sue Sharpe explains what's happening in the latest round of contract funding negotiations and what the future NHS Commissioning Body will mean for your funding

3.15pm
THE C+D SENATE
IN ASSOCIATION WITH actavis

The C+D Senate Live in association with Actavis
C+D's pharmacy think-tank holds its first ever live event. An expert panel will discuss the big issues impacting on grassroots pharmacy practice and will field questions from the audience.

Don't miss this unique chance to be part of the debate. Panellists include Ian Facer, NPA; Rob Darracott, CCA; Sue Sharpe; Michael Cann; David Reissner; RPS English Pharmacy Board chair Lindsey Gilpin; and Jonathan Mason, national clinical director for pharmacy, Department of Health.

Every session will include an audience Q+A PLUS interactive voting technology

Monday, October 11

10.20am
The new white paper – where next for NHS services?
Alan Milburn, former secretary of state for health.
The government's vision for primary care will see GPs charged with commissioning local services as PCTs are consigned to the scrap heap. Alan Milburn examines whether the new NHS blueprint will change the NHS landscape for better or for worse

11.00am
A multiple's view of the new look NHS
Andy Murdock, director of pharmacy, Lloydspharmacy
Following the white paper theme, Lloydspharmacy's Andy Murdock identifies the opportunities and threats that pharmacy faces under the latest NHS revolution

11.40am
What the new dawn in pharmaceutical wholesaling means at the coal face
Mark James, managing director, AAH
Quotas, DTP, discounts and parallel trading – the supply chain is the one topic that affects every pharmacist. Mark James cuts through the crossfire and looks for a workable solution

12.20pm
Generics, the NHS, and you
Michael Cann, chairman, BGMA
Love 'em or hate 'em, generics play a major part in keeping the NHS drugs bill down. Michael Cann looks at the opportunities that generics provide for pharmacists including category M and generic substitution

1.00pm
How ditching toiletries and cosmetics helped boost our healthcare business
Kenny Black, managing director, Rowlands Pharmacy
Rowlands Pharmacy has piloted a new front of shop business model which has seen toiletries and cosmetics replaced with a greater focus on healthcare. Kenny Black explains why pharmacy must change and shares top tips from the Rowlands experience

1.40pm
Where next for commissioning – what's important for pharmacy?
Julie Wood, director, clinical commissioning, NHS Alliance
There's no escaping the 'c' word – it's a fact that commissioning is going to be a big part of pharmacy's future. Julie Wood offers her views on what's important for pharmacy as commissioners and as providers of services

2.20pm
An examination of Co-op's blueprint for pharmacy
Chris Brooker, business development director, The Co-op
The Co-operative Pharmacy is one of the fastest growing [illegible] chains. Chris Brooker shares the company's blueprint [illegible] offers his tips on maximising your business

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